COMMONWEALTH of VIRGINIA

Department of Medical Assistance Services

http://www.dmas.virginia.gov

AMBULANCE

ENROLLMENT PACKAGE

Contents:

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First Health Services Corporation

Fiscal Agent for Virginia's Medical Assistance Program – Provider Enrollment Unit

First Health
VMAP-PEU
PO Box 26803
Richmond, Virginia 23261-6803

COMMONWEALTH of VIRGINIA

Department of Medical Assistance Services

Thank you for your request to participate in the Commonwealth of Virginia's Medical Assistance Program. Requesting to become a provider does not constitute automatic acceptance into the Program. Upon receipt of your completed Enrollment Application, processing of the enrollment may take up to 15 business days. First Health is unable to accept altered agreements or agreements without a signature. Additionally, the application will be returned if any portion is filled out incorrectly and/or missing information.

Enclosed is the Virginia Department of Medical Assistance Services, Provider Enrollment Application. This application is required for initial enrollment in any of the Virginia Medical Assistance Programs including the enrollment of additional locations. Each practice location must be enrolled separately. A completed Enrollment Application must include the Enrollment Application, Address Form, Participation Agreement, and any required licensure documents. **Ambulance and Emergency Air Ambulance providers must submit a copy of their Emergency Medical Services Certificate with the completed Enrollment Application. For higher rates of reimbursement, the Interim Settlement Agreement must be agreed to by completing the DMAS Information Request (Exhibit A) and signing the Transportation Consent Form (Exhibit B).** If the requested date of enrollment is more than one year in the past, supporting documentation and a claim for services rendered must be submitted with the completed Enrollment Application.

Out-of-State Enrollment in Virginia Medical Assistance Programs

A provider must be located within 50 miles of Virginia's border to be enrolled as an in-state provider. When a provider not within the 50-mile radius renders services to recipients, the provider can request enrollment for the date(s) of service only. To be reactivated in any of the Virginia Medical Assistance Programs, out-of-state providers must submit claims for services rendered and a letter requesting reinstatement to the Provider Enrollment Unit.

First Health Services Corporation (FHSC), fiscal agent for Virginia's Medical Assistance Program, administers all provider enrollment functions for Virginia Medicaid. First Health's Provider Enrollment Unit is available during the hours of 8:00 A.M. and 5:00 P.M. EST, Monday through Friday, to answer any enrollment questions you may have.

You may contact a Provider Enrollment Representative by calling:

1-888-829-5373 (In-state Toll Free)
OR
804-270-5105

Electronic copies of all Virginia Medicaid enrollment forms can be found at the Virginia Department of Medical Assistance Services website at (www.dmas.virginia.gov). **All applicants should visit the Virginia Department of Medical Assistance Services website and review the Transportation Manual for their specific provider participation requirements.** Completed Enrollment Applications should be mailed or faxed to First Health's Provider Enrollment Unit at the following address or fax number:

First Health
VMAP-PEU
PO Box 26803
Richmond, Virginia 23261-6803

804-270-7027 (Fax)

First Health Services Corporation

ENROLLMENT FORM INSTRUCTIONS

GENERAL INSTRUCTIONS

1. Provider Program

The Virginia Medical Assistance Program(s) for which you are requesting enrollment. Note: Medallion II is the Virginia Medicaid Health Maintenance Organization (HMO) program.

2. Requested Effective Date of Enrollment

Enter the date that you are requesting your enrollment to begin.

3. Existing Virginia Medicaid Provider Numbers

If previously enrolled, list all Virginia Medicaid provider numbers assigned.

4. Legal Business Name.

The name of the business as registered with the Internal Revenue Service. This name is used to generate and report 1099 information each year. A provider doing business under his/her own name should leave this section blank.

Individual Provider Name.

Individual providers are enrolled under the last name, first name, middle initial and professional title (e.g., M.D.). This name is used to generate claim payments and report 1099 information.

5. License/Certification Number

The license number stated on your medical license from the **Virginia Department of Health Professions**. **Out-of-state providers must attach a legible copy of their licensure to the completed Enrollment Application.** If you have multiple licenses to report, please attach a separate sheet.

6. Specialty Codes

The primary specialty is first. Enter the date you were certified for your specialty. If you are certified in more than two specialties attach an additional sheet indicating the specialty and the effective dates. If you are a physician and you have a specialty, but do not include it on your Medicaid application, you will not be reimbursed for services that require a specialty certification for payment.

7. FDA Mammography Certification.

Enter your FDA Mammography Certification number. Enter the original issuance and expiration dates. You must include a legible copy of your FDA Mammography Certification with this application.

8. UPIN Number.

Enter your six (6) digit Medicare Universal Provider Identifier Number or your UPIN on this line, if available. **Enter the unique UPIN for the enrolled provider and not the same number for each provider in a practice.**

9. DEA Number.

Enter your Drug Enforcement Agency number. If applicable, attach a legible copy of your DEA license to the Enrollment Application.

10. IRS Name

Enter your IRS Name as it is registered with the IRS.

11. Social Security Number

The Social Security Number (SSN) of the individual provider if the provider is not personally incorporated under an Employee Identification Number (EIN). This is mandatory per Section 610g(a) of the Internal Revenue Code. For identification purposes, you must furnish your social security number. Additionally, Sections 1124(a)(1) and 1124A of the Social Security Act require that you disclose your social security number to receive payment.

OR

12. Employer Tax ID Number

Enter your Employer Identification Number (EIN). This is mandatory per Section 610g(a) of the Internal Revenue Code unless you are a member of a group that bills for services you render under the group Medicaid number, or you are individually incorporated.

13. Type of Applicant

Indicate the Type of Applicant: Individual, Limited Liability Partner, Sole Proprietorship, Corporation Partnership, Group Practice, or Hospital Based Physicians Health Maintenance Organization.

14. Facility Rating

Indicate whether the Facility is Profit, Non-Profit, or Not Applicable.

15. Facility Control

Indicate the Facility Control: State, Private, Public, City, Charity, or Not Applicable.

16. Fiscal Year End

The month in which your fiscal year ends and the effective dates of the fiscal year. If there is not an End Date, leave this section blank.

17. Administrator's Name

The name of the administrator of your practice or facility.

18. Number of Beds

If you are an institution, enter the number of beds for each type.

19. CLIA Number (Laboratory Services)

To be in compliance with the Center for Medicare and Medicaid Services (CMS) Clinical Laboratory Improvement Amendments (CLIA) of 1998, all laboratory testing sites must have a CLIA certificate of waiver or certificate of registration to legally perform laboratory services rendered on or after September, 1992. If you perform laboratory services, attach a copy of the CLIA certificate of waiver or certificate of registration.

ALL FORMS MUST BE SIGNED AND DATED

First Health Services Corporation

ADDRESS FORM INSTRUCTIONS

GENERAL INSTRUCTIONS

The Address Form allows providers to indicate their Servicing Address and where they would like to receive Department of Assistance Services correspondence, payments, and remittance advice. If publications are to be sent to a billing agent, business office or any address other than the Servicing Address, the provider is responsible for obtaining the information for review and abiding by the regulations set forth in the publications.

- Provider manuals, manual updates, and memoranda may be accessed via the Department of Medical Assistance Services website at www.dmas.virginia.gov.
- The EDI Manual and updates may be accessed via the First Health Services EDI website at http://virginia.fhsc.com.

1. Servicing Address (Mandatory)

Indicate the physical location (street address) of where the provider renders services. Post office box addresses are not acceptable. Your Enrollment Application will be returned if submitted with a post office box address in this section. If you have more that one servicing location, you must submit a completed Enrollment Application for each location. If the Servicing Address is the only address provided, all Department of Medical Assistance Services correspondence, payments, and Remittance Advice will be sent to the Servicing Address.

2. Mail-To Address (Optional)

Indicate the address to which you would like Department of Medical Assistance Services correspondence (manual updates, memoranda, etc.) sent. A post office box address is acceptable. If this section is left blank, correspondence will be sent to the Servicing Address.

3. Pay-To Address (Optional)

Indicate the address to which you would like Department of Medical Assistance Services payments for services rendered sent. A post office box address is acceptable. If this section is left blank, payments will be sent to the Remittance-To Address. If there is no entry in the Remittance-To address section, payments will be sent to the Servicing Address.

4. Remittance-To Address (Optional)

Indicate the address to which you would like Department of Medical Assistance Services Remittance Advice sent. A post office box address is acceptable. If this section is left blank, the Remittance Advice will be sent to the Pay-To Address. If there is no entry in the Pay-To Address section, the Remittance Advice will be sent to the Mail-To address. If there is no entry in the Mail-To address section, the Remittance Advice will be sent to the Servicing Address.

For First Health's Use Only

Tracking Number_____

Provider Number_____

Base ID_____

Provider Type _____

VIRGINIA MEDICAL ASSISTANCE PROGRAM PROVIDER ENROLLMENT APPLICATION

All applicants must fill out the Enrollment Application. The attached instructions contain the details that apply to each type of provider. A signed provider Participation Agreement is also required and must be submitted with each enrollment application.

THIS FORM IS TO BE USED FOR INITIAL AND ADDITIONAL ENROLLMENTS ONLY

1. **PROVIDER PROGRAM:** ___ Medicaid ___ Medallion ___ Medallion II ___ State and Local Hospital (SLH)

   ___ Client Medical Management (CMM)

   ___ Temporary Detention Order (TDO)

   ___ Family Access to Medical Insurance Security Plan (FAMIS)

2. **REQUESTED EFFECTIVE DATE OF ENROLLMENT** _____

3. **EXISTING VIRGINIA MEDICAID PROVIDER NUMBERS** _____ _____

   _____ _____ _____

4. **LEGAL BUSINESS NAME:** _____
   (If applicable, as registered with the Internal Revenue Service)

   OR

   INDIVIDUAL NAME: _____ **SUFFIX** _____ **TITLE** _____
   (Name of the provider who performs the service)

5. **LICENSE/CERTIFICATION NUMBER** _____ **LICENSING BOARD** _____

   ISSUING STATE AND ENTITY _____

6. **PRIMARY SPECIALTY** _____ **LICENSING BOARD** _____

   SECONDARY SPECIALTY _____ **LICENSING BOARD** _____

7. **FDA MAMMOGRAPHY CERTIFICATION NUMBER** _____

8. **UPIN (UNIQUE PHYSICIAN/PRACTITIONER IDENTIFICATION NUMBER)** _____

9. **DEA (DRUG ENFORCEMENT AGENCY) NUMBER FOR THIS LOCATION** _____

REMARKS:

_____

_____

_____

_____

10. IRS NAME _____

11. SOCIAL SECURITY NUMBER _____ **EFFECTIVE DATE** _____ **END DATE** _____

12. EMPLOYER TAX ID NUMBER _____ **EFFECTIVE DATE** _____ **END DATE** _____

13. TYPE OF APPLICANT (Please check one)

___ **Individual** ___ **Corporation** ___ **Hospital Based Physician** ___ **Sole Proprietorship**

___ **Group** ___ **Partnership** ___ **Health Maintenance Organization (HMO)**

___ **Limited Liability Partner**

14. FACILITY RATING (Please check one)

___ **Profit** ___ **Non-Profit** ___ **Not Applicable**

15. FACILITY CONTROL (Please check one)

___ **State** ___ **Private** ___ **Public**

___ **City** ___ **Charity** ___ **Not Applicable**

16. FISCAL YEAR END

Month _____ **Begin Date** _____ **End Date** _____

17. ADMINISTRATOR'S NAME _____

18. NUMBER OF BEDS

___ **NF** ___ **SNF-NF** ___ **SNF**

___ **ICF-MR** ___ **Non-Cert** ___ **Specialized Care**

19. CLIA NUMBER _____

SIGNATURE _____ **DATE** _____

REMARKS:

_____

_____

_____

_____

ADDRESS FORM

PROVIDER NAME _____ **TAX ID NUMBER** _____

SERVICING ADDRESS (Physical location where provider renders services)

Attention _____

Address _____
Street **Room/Suite** **City** **State** **Zip**

Office Phone _____ **Ext.** _____ **24 Hour Phone** _____

TDD Phone _____ **Fax Number** _____ **E-Mail Address** _____

Contact Name _____ **Contact Phone** _____

CORRESPONDENCE ADDRESS (This address will be used to send forms, memoranda, etc.)

Attention _____

Address _____
Street **Room/Suite** **City** **State** **Zip**

Office Phone _____ **Ext.** _____ **24 Hour Phone** _____

TDD Phone _____ **Fax Number** _____ **E-Mail Address** _____

Contact Name _____ **Contact Phone** _____

PAY TO ADDRESS

Attention _____

Address _____
Street **Room/Suite** **City** **State** **Zip**

Office Phone _____ **Ext.** _____ **24 Hour Phone** _____

TDD Phone _____ **Fax Number** _____ **E-Mail Address** _____

Contact Name _____ **Contact Phone** _____

REMITTANCE ADVICE ADDRESS

Attention _____

Address _____
Street **Room/Suite** **City** **State** **Zip**

Office Phone _____ **Ext.** _____ **24 Hour Phone** _____

TDD Phone _____ **Fax Number** _____ **E-Mail Address** _____

Contact Name _____ **Contact Phone** _____

SIGNATURE _____ **DATE** _____

COMMONWEALTH of VIRGINIA

Department of Medical Assistance Services

Medical Assistance Program

Ambulance Participation Agreement

This is to certify:

Provider Name _____ Medicaid Provider Number _____

on this _____ day of _____ , _____ agrees to participate in the Virginia Medical Assistance Program (VMAP), the Department of Medical Assistance Services, the legally designated State Agency for the administration of Medicaid.

1. The provider is authorized to provide transportation under the laws of the state in which he is licensed and is not as a matter of state or federal law disqualified from participating in the Program.
2. Services will be provided without regard to age, sex, race, color, religion, national origin, or type of illness or condition. No handicapped individual shall, solely by reason of his handicap, be excluded from participation in, be denied the benefits of, or be subjected to discrimination in (Section 504 of the Rehabilitation Act of l973 (29 USC §794) VMAP.
3. The provider agrees to keep such records as VMAP determines necessary. The provider will furnish VMAP on request information regarding payments claimed for providing services under the State Plan. Access to records and facilities by authorized VMAP representatives and the Attorney General of Virginia or his authorized representatives, and federal personnel will be permitted upon reasonable request.
4. The provider agrees that charges submitted for services rendered will be based on the usual, customary, and reasonable concept and agrees that all requests for payment will comply in all respects with the policies of VMAP for the submission of claims.
5. Payment made by VMAP constitutes full payment except for patient pay amounts determined by VMAP, and the provider agrees not to submit additional charges to the recipient for services covered under VMAP. The collection or receipt of any money, gift, donation or other consideration from or on behalf of a medical assistance recipient for any service provided under medical assistance is expressly prohibited.
6. The provider agrees to pursue all other available third party payment sources prior to submitting a claim to VMAP.
7. Payment by VMAP at its established rates for the services involved shall constitute full payment for the services rendered. Should an audit by authorized state or federal officials result in disallowance of amounts previously paid to the provider by VMAP, the provider will reimburse VMAP upon demand.
8. The provider agrees to comply with all applicable state and federal laws, as well as administrative policies and procedures of VMAP as from time to time amended. The provider agrees to comply with the regulations of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), including the protection of confidentiality and integrity of VMAP information.
9. This agreement may be terminated at will on thirty days' written notice by either party or by VMAP when the provider is no longer eligible to participate in the Program.
10. All disputes regarding provider reimbursement and/or termination of this agreement by VMAP for any reason shall be resolved through administrative proceedings conducted at the office of VMAP in Richmond, Virginia. These administrative proceedings and judicial review of such administrative proceedings shall be pursuant to the Virginia Administrative Process Act.
11. This agreement shall commence on _____. Your continued participation in the Virginia Medicaid Program is contingent upon the timely renewal of your license. Failure to renew your license through your licensing authority shall result in the termination of your Medicaid Participation Agreement.

For First Health's use *only*

Director, Division of Program Operations Date

Original Signature of Provider **Date**

COMMONWEALTH of VIRGINIA

Department of Medical Assistance Services

SUITE 1300
600 EAST BROAD STREET
804/786-7933
804/225-4512 (FAX)
800/343-0634 (TDD)

Dear Virginia Medicaid Ambulance Service Provider:

On June 30,1997, the Department of Medical Assistance Services (DMAS) entered into an Interim Settlement Agreement ("the Agreement") with three ambulance providers, Richmond Ambulance Authority, Lifeline Ambulance Service, Inc., and Medical Transport, which has settled the issues raised in a lawsuit filed by those providers. According to the terms of the Agreement, any Virginia Medicaid ambulance service provider that elects to consent to the terms and limitations of the Agreement will be paid higher reimbursement rates for ambulance services than those currently paid under the Medicaid program. This letter is to notify you of your option to consent to the terms of the Agreement, and receive the higher rate of reimbursement. Enclosed please find a complete copy of the Agreement, along with a Provider Consent Form.

Under the terms of the Agreement, you must accept payment at these higher rates as payment in full for services provided during the term of the Agreement. By consenting to the Agreement, you agree to abide by all terms of the Agreement.

In order to consent to the Agreement, you must sign and date the Provider Consent Form and return it to DMAS. For new enrollments, the higher rates will be paid to you beginning on the effective date of your enrollment, *provided you return the Consent Form **along** with your participation agreements*. For already enrolled providers or providers who return the Consent Form separately from their participation agreements, the higher rates will be paid to you beginning effective the date of DMAS receipt of your Consent Form. In no event will the higher rates be paid for dates prior to July 1, 1997. Original signatures are required on the Consent Form (Exhibit B). Additionally, you must submit the documentation requested in Exhibit A, DMAS INFORMATION REQUEST.

Thank you for your assistance in this matter.

Sincerely,

Provider Enrollment/Certification Unit

Enclosures

EXHIBIT C

VIRGINIA:

IN THE UNITED STATES DISTRICT COURT
FOR THE EASTERN DISTRICT OF VIRGINIA

RICHMOND AMBULANCE AUTHORITY,	**)**	
LIFELINE AMBULANCE SERVICE, INC. and	**)**	
MEDICAL TRANSPORT,	**)**	
	)	
Plaintiffs.	**)**	
	)	
v.	**)**	**CaseNo.: 3:97CV099**
	)	
GEORGE ALLEN, GOVERNOR OF	**)**	
THE COMMONWEALTH OF VIRGINIA,	**)**	
ET AL.,	**)**	
	)	
Defendants.	**)**	

ORDER OF DISMISSAL WITHOUT PREJUDICE

This cause came to be heard on the _____ day of June, 1997, upon agreement by counsel for all parties. Upon consideration whereof, and in view of the Interim Settlement Agreement reached by said parties. it is ORDERED that this action is dismissed without prejudice.

ENTER:

_____

DATE:

_____

INTERIM SETTLEMENT AGREEMENT

This Interim Settlement Agreement (the "Agreement") is made this 30th day of June, 1997, by and between Richmond Ambulance Authority, Lifeline Ambulance Service, Inc., and Medical Transport (collectively "Ambulance Services") and those parties defendant who are officials of the Commonwealth of Virginia (the "Commonwealth Officials"), in settlement of the issues raised in Richmond Ambulance Authority. et al. v. Allen. et al., Civil Action No. 3:97CV099, presently pending in the United States District Court for the Eastern District of Virginia (the "Medicaid Litigation") and provides that:

WHEREAS, the Ambulance Services filed the Medicaid Litigation in 1997, naming various officials of the Commonwealth as defendants, challenging their promulgation and enforcement of the State Plan for Medical Assistance Services (the "State Plan"), specifically Attachment 4.19-B, §10, and alleging that the State Plan did not establish payment rates for ambulance transportation services consistent with efficiency, economy and quality of care and sufficient to enlist enough providers as required by the Medicaid Act;

WHEREAS, the Ambulance Services and the Commonwealth Officials have agreed to dismiss the Medicaid Litigation without prejudice based upon the Commonwealth Officials' agreement to set higher interim payment rates and commission a study to evaluate Medicaid reimbursement rates for transportation providers (the "Study");

WHEREAS, the Ambulance Services and the Commonwealth Officials have entered into an Agreement in principle on June 3, 1997, and desire to effectuate such principles establishing certain terms for the reimbursement of ambulance transportation services upon which Medicaid payment rates will be based beginning July 1, 1997 and ending on June 30, 1998;

NOW, THEREFORE, for and in consideration of the mutual covenants and promises set forth herein, and other good and valuable consideration, the parties agree as follows.

1.00 **Reimbursement Terms**. The Commonwealth Officials agree to pay the Ambulance Services, and any other ambulance service provider who elects to consent to this Agreement ("Participating Provider") as provided in Section 2.02 of this Agreement, pursuant to the rate schedules set forth in §§ 1.01 and 1.02 of this Agreement (the "Interim Rates"); provided, however, that a Participating Provider shall be paid at the Interim Rates only for services provided by such Participating Provider after the date it executes and delivers a Provider Consent Form to the Director of the Department of Medical Assistance Services ("DMAS"). The Ambulance Services and the Participating Providers agree to accept payment at the interim rates as payment in full for services provided during the term of this Agreement, unless a higher ambulance service rate of general application is adopted by DMAS other than as the result of a court challenge brought by other Medicaid providers or users of ambulance services.

1.01 **Ambulance Ground Transportation Services - General**. The use of this service is restricted to patients who need emergency transportation or who require transportation by stretchers. Payment rates for this mode of transportation service are as follows:

	Service Dates From July 1, 1997 to December 31, 1997:	**Service Dates From January 1, 1998 to June 30, 1998:**
1-5 miles	$ 62.50	$ 75.00
6-10 miles	$125.00	$150.00
Over 10 miles	$2.10 each additional mile	$2.50 each additional mile
Wait time	$21.00 per hour	$25.00 per hour

To bill for round trips, the provider shall mark round trip on the billing invoice and compute the charges as two one-way trips.

Mileage is determined from the pick up point to the drop off point.

Waiting time is covered by the Medical Assistance Program and begins when the provider remains for more than one-half hour at the location where the recipient is picked up or taken. Waiting time is covered for all trips without regard to the number of transport miles.

1.02 **Ambulance Ground Transportation Services - Neonatal**.

The use of this service is restricted to neonatal patients who require ambulance transportation by licensed Class D-neonatal ambulances. Payment rates for this mode of transportation service are as follows:

	Service Dates From July 1, 1997 to December 31, 1997:	**Service Dates From January 1, 1998 to June 30, 1998:**
Each trip	$120.00	$120.00
All Miles	$ 6.00	$ 6.00
Wait Time	$ 21.00	$ 25.00

Mileage is determined from the dispatch point to the drop off point.

Waiting time is covered by the Medical Assistance Program when the provider remains for more than one-half hour at the location the recipient is picked up or taken. Waiting time is covered for all trips without regard to the number of transport miles.

Charges shall not exceed $1200.00 in total for all reimbursement categories (round trips, base rate, mileage and wait time).

2.00 **General Terms.**

2.01

A. The Commonwealth Officials agree that the Ambulance Services, and such Participating Providers as may be conveniently included by DMAS, shall be provided an opportunity to meet with Study representatives, including Joseph Teefey and the Study consultants, prior to the implementation of the Study and periodically throughout the Study period at mutually agreeable meeting dates to provide input and to review and comment on the ongoing Study. The Commonwealth Officials shall timely provide all Study related information in hard copy and electronic format, where available, to the Ambulance Services to the same extent as would be available under the Virginia Freedom of Information Act ("VFOIA"), but without the need for any additional requests by the Ambulance Services. If the Commonwealth Officials determine that any such information is exempt from disclosure under VFOIA, then they shall notify the Ambulance Services of such determination, identify the documents and state in writing why such information is not available, citing the specific VFOIA exemption provision which applies. Notwithstanding the foregoing, all cost data submitted to Commonwealth Officials or DMAS shall be made available to the Ambulance Services; however, the data shall have the provider name and other like identifying information redacted from it and replaced with a confidential code.

B. Insofar as it relates to the rate paid ambulance providers, the Study shall be completed by November 3, 1997. The Ambulance Services and Participating Providers agree to provide financial information on their services as may be reasonably requested by the Commonwealth Officials in a format in which they currently maintain such information and to provide such other information or respond to survey requests to the extent such information is reasonably available to them. Information shown on Exhibit A shall be deemed reasonably requested; however, the parties recognize that not all such information may be available from all ambulance services. Nothing herein shall, however, be deemed to require any party to produce information in their possession in a form in which it does not already exist.

2.02 Any provider of ambulance transportation services who is eligible to receive Medicaid reimbursement in the Commonwealth pursuant to the State Plan during the term of this Agreement may consent to be bound by this Agreement and be subject to all of the terms set forth herein to the same extent as the Ambulance Services (except 2.01(A)) by executing a Provider Consent Form, a copy of which is attached hereto as Exhibit B and incorporated herein; provided, however, that a Participating Provider shall be entitled to said rates only for services provided by such Participating Provider after the date it executes and delivers a Provider Consent Form to the Director of DMAS. The Commonwealth Officials agree to provide all Medicaid ambulance service providers with a copy of this Agreement and Exhibits which notice shall plainly advise them of their right to obtain increased reimbursement rates by becoming Participating Providers.

2.03 The parties agree (i) that the Medicaid Litigation shall be dismissed without prejudice, (ii) that neither the Ambulance Services nor any Participating Provider shall institute any other action challenging Medicaid reimbursement rates until after December 1, 1997, and (iii) that, if such a suit is thereafter brought, any relief sought or to be granted in such action shall not commence prior to July 1, 1998, the date on which the rates set under §1.00 expire, nor may it retroactively grant relief for ambulance services rendered prior to July 1, 1998. In the event the court declines to enter an order dismissing the Medicaid Litigation without prejudice in substantially the form attached as Exhibit C, then this Agreement shall be null and void.

2.04 The Commonwealth Officials agree not to amend the State Plan, Attachment 4.19-B, or other regulatory documents or policies in a manner which will circumvent this Agreement. The Commonwealth Officials agree to amend the State Plan as may be necessary to implement this Agreement. The Commonwealth Officials reserve the right to amend the State Plan or to take any other action necessary (i) to make federally mandated changes or (ii) to make changes required by a federal or state court of competent jurisdiction.

2.05 The parties shall bear their own costs and attorneys fees, including, but not limited to, all costs, expenses and expert witness fees incurred in the Medicaid Litigation or the Study and shall make no claim upon the other party for reimbursement of such costs and fees. Costs, attorneys fees and expert witness fees, if any, that may be available under 42 U.S.C. §1988, or otherwise, should the Ambulance Services commence another action after December 1, 1997 challenging Medicaid rates which are or will be effective on or after July 1, 1998 are not barred by this Agreement.

2.06 Nothing contained herein shall be construed to obligate the General Assembly to accept, approve or fund the rates produced by the Study. The Commonwealth Officials agree to seek funding for such Study rates during the 1998 Session of the Virginia General Assembly. On or before April 1, 1998, the Director of DMAS shall: (a) determine whether or not the General Assembly included in its appropriation for DMAS for the biennium beginning July 1, 1998, the amount requested by DMAS to fully fund the study rate, and (b) provide written notice of this determination to the Ambulance Services and to the Participating Providers. If the Director determines that insufficient funds were so appropriated, then the Director shall notify the Ambulance Services and the Participating Providers on or before May 1, 1998, of the rates to be paid in the biennium beginning July 1, 1998, and of any changes to the initial determination caused by the action of the General Assembly during the 1998 reconvened session.

2.07 This Agreement constitutes the parties' interim resolution of issues and is not a final settlement of the Medicaid Litigation.

2.08 The parties shall cooperate fully and in good faith with each other in conducting and participating in the Study.

2.09 This Agreement shall be binding upon the parties and all Participating Providers, subject to the contingencies provided for herein. Neither party admits the validity of the legal or factual positions taken by the other party in the Medicaid Litigation and nothing herein shall constitute an admission against interest by any such party or by any Participating Provider. Neither payment nor acceptance of payment pursuant to the rates set under § 1.00 above shall be used in any future proceedings as to what rate may be lawful under 42 U.S.C. § 1396a(a)(30)(A).

2.10 This Agreement shall inure to the benefit of, and be binding on, the parties hereto and the consenting providers, as well as their successors and assigns.

2.11 This Agreement may be executed in any number of counterparts which together shall constitute one instrument.

2.12 This Agreement has been duly executed and delivered by each party to the other, and each warrants and represents that the executing officer has authority to enter into this Agreement and the same is a legal, valid and binding obligation enforceable against such party in accordance with its terms. The Commonwealth Officials further warrant this Agreement has been approved by the Governor and the Attorney General as provided in Virginia Code § 2.1-127 (1950), as amended.

2.13 This Agreement cannot be modified or amended except in writing by an instrument executed in like formality.

LIFELINE AMBULANCE SERVICE, INC.

By: _____

Title: CEO

MEDICAL TRANSPORT

By: _____

Title: Administrative Manager

RICHMOND AMBULANCE AUTHORITY

By: _____

Title: Executive Director

THE COMMONWEALTH OF VIRGINIA

By: _____

Joseph M. Teefey, Director
Department of Medical Assistance Services

EXHIBIT A

DMAS INFORMATION REQUEST

The information requested below should be provided for your last five fiscal years:

1. Identify your fiscal year (e.g., January 1 to December 31, July 1 to June 30);

2. Identify the number of ambulance runs per fiscal year, broken down by emergency and non-emergency runs, and within each category, by Medicaid and Non-Medicaid runs.

3. Provide the total cost of ambulance services for each fiscal year, allocated between emergency and non-emergency services, together with an explanation of how the allocation was made.

4. State total revenues per fiscal year for ambulance services, breaking such revenues down between emergency and non-emergency services and, within each category, by Medicaid and non-Medicaid source of payment.

5. Identify the rates charged during each fiscal year for each category of ambulance service and each category of patient, based on the categories actually used for computing charges.

6. Provide a copy of your financial statements for each fiscal year, audited if available.

PROVIDER CONSENT FORM

WHEREAS, Richmond Ambulance Authority, Lifeline Ambulance Service, Inc. and Medical Transport (collectively "Ambulance Services") and certain officials of the Commonwealth of Virginia (the "Commonwealth Officials") have entered into an Interim Settlement Agreement, dated June w 1997, (the "Agreement") which has settled the issues raised in Richmond Ambulance Authority. et al. v. Allen. et al., U.S.D.Ct., E.D. Va., Civil Action No. 3:97CV099 (the "Medicaid Litigation") pending completion of a rate study by the Department of Medical Assistance Services;

WHEREAS, the undersigned provider is a provider of ambulance transportation services who is eligible to receive Medicaid reimbursement in the Commonwealth pursuant to the State Plan during the term of the Agreement;

WHEREAS, the undersigned provider has received and reviewed a copy of the Agreement and, in consideration of the benefits accruing to the undersigned as a Participating Provider upon the implementation of the Agreement and the execution and delivery of this Provider Consent Form, the undersigned provider has determined to consent to, accept and be bound by the terms of the Settlement Agreement, as if the undersigned provider was a party thereto, in accordance with its terms.

NOW, THEREFORE, the undersigned provider, through the execution hereof by its duly authorized officer in consideration of the benefits which will accrue to it under the Agreement and other good and valuable consideration, does hereby consent to and accept the Agreement and agrees to be bound by and comply with its terms.

Date _____ Name of Provider _____

Provider ID _____ By _____

Chief Executive Officer

First Health Services Corporation

MAILING SUSPENSION REQUEST

SIGNATURE WAIVER

PHARMACY POINT-OF-SALE

Please review and check the blocks, which pertain to you:

- ☐ **MAILING SUSPENSION REQUEST:**
  I do not wish to receive Medicaid correspondence under the Medicaid provider number given below.
- ☐ **SIGNATURE WAIVER:**
  I certify that I have authorized submission of claims to Virginia Medicaid, which contain my typed, computer generated, or stamped signature.
- ☐ **PHARMACY POINT-OF-SALE AUTHORIZATION (in-state providers only):**
  I wish to submit Point-of-Sale billings to Virginia Medicaid.

I understand that I am responsible for the information presented on these invoices and that the information is true, accurate, and complete. I further understand that payment and satisfaction of these claims will be from federal and state funds and that false claims, statements, documents, or concealment of material facts may be prosecuted under applicable federal and state laws.

PROVIDER NAME: _____

PROVIDER NUMBER: _____ Leave blank, if number pending.

SIGNATURE: _____

DATE: _____

TELEPHONE # _____

Please return the completed form to:

First Health
VMAP-PEU
PO Box 26803
Richmond, Virginia 23261-6803

804-270-7027 (Fax)

First Health
Services Corporation

REQUEST FOR TITLE XVIII (MEDICARE) INFORMATION

Medicare crossover payment information is an exchange of claim information between Medicare and Medicaid. If the Medicaid enrollee has Medicare as their Primary/Secondary carrier, the Medicare information is transferred to Medicaid for remaining payment, thus eliminating the need for claim submission. First Health Services is requesting information from you to automate the payment of claims paid by Medicare for Recipients that are also eligible under the Virginia Medical Assistance Program. Please indicate your Medicare number, if you have been assigned one, by your Medicare intermediary. You will not be reimbursed for Medicare crossover claims unless you supply this number. The Medicare number you indicate below will be the number that Medicaid will use to reimburse you for Medicare crossover claims. Please allow 30 days for processing of the Medicare Information Form and commencement of automated Medicare crossover.

PROVIDER NAME _____

MEDICAID PROVIDER NUMBER _____
LEAVE BLANK, IF NUMBER PENDING

MEDICARE CARRIER _____

MEDICARE PROVIDER NUMBER _____

TELEPHONE #_____

SIGNATURE_____ **DATE** _____

Please return the completed form to:

First Health
VMAP-PEU
PO Box 26803
Richmond, Virginia 23261-6803

804-270-7027 (Fax)

First Health
Services Corporation

ELECTRONIC FUNDS TRANSFER

Would you like your Medicaid and FAMIS checks to be automatically deposited in the account of your choice? If you want to participate in the Electronic Funds Transfer (EFT) program, just complete the enclosed form, tape a voided check to the form and mail or fax it to First Health at the address given below.

The start-up of EFT for a provider includes a two-week test period in which the banking institution and First Health tests the accuracy of the transfer of funds to a provider's bank account and the resolution of any detected errors. There is not a disruption in the routine disbursement of Medicaid claim payments as a paper check is generated with the provider's Remittance Advice during the test period. Upon completion of testing, the weekly deposit of funds takes place on the first business day after the Remittance date, which is typically a Monday.

The First Health Services, EFT Enrollment Representative will track the enrollment of all providers in EFT and will monitor the process each week to detect problems that may arise.

Please keep in mind the following when enrolling for EFT:

- Submit an **original** signature.
- Submit one form for each provider number.
- **All** payments for the provider number must go to the same account.
- Processing time will be a minimum of 30 days from receipt of the completed form.

First Health
VMAP-PEU
PO Box 26803
Richmond, VA 23261-6803

804-270-7027 (Fax)

First Health Services Corporation

Electronic Funds Transfer Application

GENERAL INFORMATION

Provider Name	Tax ID Number	Provider I.D. Number

Address	City	State	Zip

Authorization Agreement For Automatic Deposits (CREDITS)

I hereby authorize FIRST HEALTH **and its subsidiaries to initiate credit entries, if necessary, debit entries and adjustments for any credit in error for the following provider ID:**

Medicaid Provider ID	IRS Number

Printed Name _____ **Title** _____

Signature _____ **Date** _____

This authorization is to remain in full force until FIRST HEALTH **or the financial institution has received written notification from me and/or** FIRST HEALTH **of its cancellation in a timely manner so as to afford** FIRST HEALTH **and the financial institution a reasonable opportunity to act on it, or until the financial institution's cancellation of the agreement.**

☐ **Personal Account** ☐ **Business Account**

Place tape on this side ⟷

TAPE VOIDED CHECK HERE